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Racial and Ethnic Approaches to Community Health

Reducing Health Disparities by Addressing Social Determinants of Health

Joyce Buckner-Brown, PhD, MHS, RRT; Pattie Tucker, BSN, MPH, DrPH; Mark Rivera, PhD; Shannon Cosgrove, MHA; James L. Coleman, EdD; Aisha Penson, MEd, CHES; David Bang, PhD, MPH, CHES

Poor people and people of color are more likely to live shorter and sicker lives and are less likely to survive a host of chronic illnesses. Policies and organizational practices that improve the environments in which people live, work, learn, and play can reduce these disparities. Using the World Health Organization's "*Call to Action*" principles as a discussion framework, we highlight the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health programs that have developed and applied such strategies to address chronic illnesses. Several, in turn, foster health equity. **Key words:** *health disparities*, *health equity*, *racial and ethnic approaches to community health*, *social determinants of health*

Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied to a single garment of destiny. Whatever affects one directly affects all indirectly.[1(p1)]

RECOGNIZED KEY STUDIES—The Heckler Report on Black and Minority Health,[2] the Institute of Medicine's *Confronting Racial and Ethnic Disparities in Healthcare*,[3] the Medical Expenditure Panel Survey's *Comparing Urgent Medical Care*,[4] and the Agency for Healthcare Research and Quality's *National Healthcare Disparities Report*[5]—comprehensively documented that health disparities exist in racial and ethnic populations. They exist despite substantial advances in the overall health of Americans. Social and environmental factors, disparities in education, and cultural beliefs can play a role in health disparities. Racial and ethnic minority populations are more likely to experience racism and poverty. They are also more

Author Affiliations: *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (Drs Buckner-Brown, Tucker, Rivera, and Bang and Ms Cosgrove); Northrop Grumman (Ms Penson), Atlanta, Georgia; and Wateree Community Action, Inc, Sumter, South Carolina (Dr Coleman).*

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Correspondence: *Joyce Buckner-Brown, PhD, MHS, RRT, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, 4770 Buford Hwy, NE, Mailstop K30, Atlanta, GA 30341 (jbucknerbrown@cdc.gov).*

likely to lack access to safe and affordable housing, high-quality education, fresh and affordable fruits and vegetables, transportation, and culturally appropriate interventions and services.[6] The reports cited conclude that addressing health disparities requires greater attention to these social determinants of health and calls for multisectorial and transdisciplinary partnerships with community collaborators to unite resources and efforts.

The last few decades of public health research has transformed our understanding of the factors that prevent chronic diseases. Although health outcomes had been attributed to biological causes largely brought about by poor life-style choices, evidence now supports the conclusion that health cannot be adequately explained as predominantly an outcome of "wrong health behaviors." Public health researchers and practitioners are placing greater emphasis on the influence of social and physical environments on our health-related decisions and behaviors. Case in point: Albain et al[7] conducted a study for the period 1974 to 2001 with nearly 20000 cancer patients nationwide. They found that the gap in survival between blacks and whites disappeared for lung, colon, and several other cancers when both groups received identical care as part of federally funded clinical trials. However, disparities persisted for prostate, breast, and ovarian cancers, suggesting that other factors play a role in the greater tendency of blacks having poorer health outcomes.

Understanding the factors that most influence persistent and widening health disparities is vital in designing strategic responses. Regardless of race or ethnicity, all Americans are subject to the determinants that contribute to disparities and poor outcomes—just as all Americans will become beneficiaries from the policies implemented to eliminate disparities. Underscoring this need, the World Health Organization established The Commission on Social Determinants of Health in 2005 to identify recommendations to reduce them. The Commission's final report[6] was issued in August 2008 and contained 3 overarching principles for action including to

- improve the conditions of daily life;
- tackle the inequitable distribution of power, money, and resources; and
- measure and understand the problem and assess the impact of action.

Over the last decade, Racial and Ethnic Approaches to Community Health (REACH) communities have provided effective leadership in transforming their communities by designing tactical responses to improve racial and ethnic health outcomes. Moreover, they have advanced a deeper understanding of how fundamental causes of health disparities shape community environments and how these environments, in turn, shape health. REACH communities have focused on some of the most serious racial and ethnic health disparities: asthma, cancer, infant mortality, cardiovascular disease, diabetes, immunizations, and hepatitis. Their interventions have been based on culturally tailored, sound prevention research and supported by new and innovative partnerships among governments, businesses, and faith-based organizations.[8,9]

With the World Health Organization recommendation serving as a framework, we reviewed the social action models used and the policy and system changes developed and implemented by REACH Programs and their coalition partners. Our aim is to demonstrate how REACH communities are strategizing to achieve policies, systems, and environmental changes in their localities. To this end, we highlight a sample of REACH Program efforts designed to eliminate health disparities by addressing the social determinants of health.

IMPROVING DAILY LIVING CONDITIONS

HealthVisions Midwest, Inc

Infant mortality rates (IMR), the rate at which babies younger than 1 year die, is considered the most important indicator of health and well-being across and within a community or society. It also reflects the quality and accessibility of primary health care to pregnant women and infants. In Indiana, IMR have consistently been higher than the national level.

From 2004 to 2006, Indiana's IMR was 7.9 per 1000 live births while the US rate was 6.8 per 1000 live births during the same period.[10]

Throughout the 1990 to 2006 period, the IMR for Lake County—the second largest county (19 cities and towns), with the highest Hispanic/Latino population—have been higher than the rates for Indiana. In 1997 to 2006, the mortality rate for infants of Hispanic mothers in Lake County occurred at a rate of 7.6 deaths per 1000 live births.[11] This exceeded the state rate of 7.2 per 1000 live births to Indiana's Hispanic mothers during the same period.[11] The maternal and family characteristics that influence infant mortality are well documented[12] and of these characteristics, access to adequate prenatal care services is associated with improved birth weights and lower risk of preterm delivery.[12]

To address the difficulties of accessing and obtaining culturally competent and linguistically appropriate health care services, *HealthVisions Midwest*, a faith-based REACH Action Community funded by the Centers for Disease Control and Prevention in 2007, has partnered with Northern Indiana Medical Interpreters Association and HealthVisions' Alcance/REACH Program. The partnership supports the adoption of a state-wide regulated, cohesive training program that will provide consistency and oversight of medical interpreters, thereby ensuring that community health workers are trained, bilingual medical interpreters. Through this partnership, the REACH/Alcance Program serves the underestimated demand for Spanish interpreters and acts as a liaison with the health delivery system. The REACH/Alcance bilingual assistance is extended to other social programs, schools, community health care providers, and the local Medicaid office.

The Prenatal Care Coordination Program is available to all pregnant women as an extension of their routine prenatal care offering educational sessions and linkages and support services to maximize the health and well-being of both mother and infant. The level of care coordination is based on a comprehensive assessment and collaboration arrangements offered by providers who are simultaneously serving the needs of the individual. Prenatal care coordination is a qualified reimbursable service and is funded through the Indiana State department of Health through Title V funding.

The REACH/Alcance Program–integrated systems of care coordination and interpreter services are designed to have a lasting impact on the conditions of daily life for current and future generations of Lake County, Indiana Hispanic residents.

Orange County Asian and Pacific Islander Community Alliance

Native Hawaiians and Pacific Islanders are 30% more likely to be diagnosed with cancer than non-Hispanic whites.[13] Asian American and Pacific Islander (AAPI) women, in aggregate, are more likely to die from breast cancer than any other type of cancer, and certain AAPI ethnic groups have among the highest rates of cervical cancer in the United States.[14] For example, American Samoan women are twice as likely to be diagnosed with, and to die from, cervical cancer, as compared with non-Hispanic whites.[13] Research also shows that AAPI women have the lowest screening rates for cancer compared with other racial and ethnic groups.[15-19]

Orange County, California, contains a large concentration of AAPI communities and, further adding to the health disparities of AAPI women previously noted, has a very limited number of AAPI physicians who understand the cultures and beliefs of Cambodian, Chamorro, Hmong, Laotian, Marshallese, Native Hawaiian, Samoan, Thai, Tongan, and Vietnamese communities. The Promoting Access to Health for Pacific Islander and Southeast Asian Women (PATH for Women) Coalition seeks to prevent breast and cervical cancer by increasing risk protective behaviors (eg, early-stage screening) through increased breast and cervical cancer knowledge among women in California's Asian and Pacific Islander communities and across the United States. As a Center of Excellence in the

Elimination of Health Disparities, REACH U.S. PATH for Women Coalition emphasizes outreach and education activities with an intermediate goal of increasing access to health care and, in turn, the incidence of disease can be identified and treated earlier.

REACH U.S. PATH for Women strives to prepare Pacific Islander and Southeast Asian health advocates, community educators, and community leaders by increasing their knowledge and awareness of factors leading to health disparities. To accomplish this goal, they assist communities through mentoring, training, performing community mobilization, and using participatory approaches to program development and evaluation. In all of their approaches, they consider specific community issues, cultural values, health beliefs, and health practices.

REACH U.S. PATH for Women's efforts to address cancer-related health disparities in AAPI women also includes increasing health care workforce diversity. A related goal is to increase the number of Pacific Islander health care providers and health-related professionals by increasing access and preparation for educational and health career opportunities for young Pacific Islanders. Toward this end, the Orange County Asian and Pacific Islander Community Alliance built the Pacific Islander Health Careers Pipeline Program[20] a pipeline to

- increase awareness and knowledge among health care professional training programs and universities regarding the need to recruit Pacific Islanders into health careers;
- develop agreements with health care professional training programs and universities, who will develop policies to improve outreach and recruitment strategies to Pacific Islanders;
- develop partnerships with scholarship and financial aid programs that make it a policy to improve their accessibility to Pacific Islanders;
- offer training and a curriculum for Pacific Islanders to engage in health care workforce development; and
- annually educate young Pacific Islanders about health career opportunities and the health career field.[20]

Ultimately, this pipeline will promote the presence of Pacific Islanders in the health care workforce and leadership positions, foster broader adoption of culturally competent approaches when working with Pacific Island communities, and provide the health care system infrastructure needed to support a broader range of culturally appropriate programs and services to California's Pacific Island communities.

While the Pacific Islander Health Careers Pipeline Program is highlighted, it is important to note that the Orange County Asian and Pacific Islander Community Alliance and the REACH PATH for Women activities have in 5 years used a variety of outreach tools and approaches to educate more than 30 000 community members about breast and cervical cancer prevention, early detection, and treatment. Coalition members also documented more than 500 hours of training to patient navigators, who, in turn, provided services to more than 3000 women and their families across the entire cancer care continuum. These efforts were supported by their development, creation, and dissemination of more than 50 breast and cervical cancer educational materials created in Cambodian, Lao, Hmong, Thai, Vietnamese, Samoan, Chamorro, Marshallese, Hawaiian, Korean, Chinese, Hindi, Bengali, Gujarati, and Tongan languages.

TACKLING THE INEQUITABLE DISTRIBUTION OF POWER, MONEY, AND RESOURCES

YMCAs of Santa Clara Valley and Greater Cleveland

According to the World Health Organization, inequitable distribution of power, money, and resources are "produced by social norms, policies and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources."[6] In 2007, REACH

US funded 2 Young Men's Christian Association (YMCA)—Santa Clara and Greater Cleveland. Although they are geographically dissimilar and have developed different strategic responses, both have established sustaining partnerships that have resulted in systematic and cultural changes in their respective communities.

The YMCA of Silicon Valley, California, serves the Greater Gilroy area of South Santa Clara County, which has a population of more than 45 000 in this farming community.[21] The YMCA has focused on the Latino population, which has a disproportionally high rate of diabetes at 7.5% compared with 5.7% of whites according to the 2005 to 2006, Behavioral Risk Factor Surveillance System.[22] The YMCA of Silicon Valley, through the Proyecto Movimiento program, aims to reduce the prevalence of type 2 diabetes in the Latino community by reducing barriers to prevention and increasing culturally appropriate health and fitness opportunities and facilitate changes in practices and policies that promote diabetes prevention. This comprehensive approach includes a multigenerational strategy that positions Promotoras, or community health workers, and youth health advocates in the homes of the community. These grassroots leaders give voice to the community and assist with identifying unique ways of intervening in an isolated community that experiences an abundance of obstacles such as limited or no public transportation, language barriers, minimal healthy food options, gang activity, segregation, and unaffordable housing. Promotoras facilitate diabetes house meetings, diabetes management classes, and exercise classes throughout Greater Gilroy. The house meetings are held with clients living with diabetes, their family, and neighbors. The demand for the house meetings as well as the supplemental nutrition and exercise classes including Zumba, tai chi, and martial arts are high. Women are walking more than 2 miles to attend free classes held at accessible facilities (ie, community centers, schools, and churches) and taught by a community volunteer. By the end of 2009, the program reached approximately 2000 individuals in more than 50 house visits, offering more than 200 classes and 1000 screenings and referrals for diabetes prevention, management, and treatment.

The voice of the youth health advocates and *Promotoras* have been heard throughout the community, and in response the primary local grocer increased the availability and amount of fresh fruits and vegetables in her highly accessible bodega, and unhealthy snacks have essentially been banned from the schools. Health promotion messages have also been broadcast in more than 20 public service announcements including the *Soda Free Summer* campaign for students and their families, challenging participants to avoid high-caloric sweetened beverages. In addition to health messages, college preparedness courses were offered and taught by former youth health advocates. With access to health education, training, encouragement, and care, these individuals have excelled, which has resulted in an overall improvement of their lives and lives of families in the Gilroy community.[23]

The YMCA of Greater Cleveland, Ohio, relied on the voices of both youth throughout their community and the original Clevelanders in Motion Think Tank, which consist of more than 120 individuals from highly diverse sectors of the community. The YMCA of Greater Cleveland REACH Coalition is focused on reducing disparities in cardiovascular disease and diabetes among Cleveland's 239 760 black and Hispanic residents,[24] who have limited access to health care, healthy foods, and safe places to exercise. From 2004 to 2009, 4 YMCA branches located within the city of Cleveland have closed, leaving the Downtown Branch as 1 of only 2 branches within the city limits. The facilities closures resulted in a new partnership between the Clevelanders in Motion and the Cleveland Division of Recreation, this allowed programming to be offered at 6 of the recreation centers. This community presence has enabled the YMCA to more effectively promote diabetes education and management programs, like Activate Ohio—a diabetes education, support, and self-management program. The REACH and

Activate Ohio programs provide mutually supportive client services to individuals who, during a REACH recreation screening, are referred to a Downtown YMCA and who were found to be living with diabetes, have prediabetes, or are at high risk for diabetes.

In 2009, the YMCA of Greater Cleveland hosted neighborhood-walking clubs, offered walking route maps, and employed local residents most familiar with the communities as walking route leaders. The neighborhood walking maps serve both to provide information to city residents about suitable walking routes and to celebrate each community's assets via points of interest. In 2010, the walking clubs will participate in Walkability Assessment exercises wherein neighborhood walkers will be asked to identify barriers to safe walking such as broken sidewalks, malfunctioning traffic signals, and so forth. These assessments will in turn be used to inform the Complete Streets Policy initiative, which requires every roadway project that receives federal funding to provide accommodations for motorists, bicyclists, pedestrians, transit users, and other users of all ages and abilities on the same road.[25]

The YMCA of Greater Cleveland REACH Coalition is interested in improving the walkability of neighborhood streets, which led to the city's first Complete Street Project, the Euclid Corridor "Health Line" project. Input from these walking clubs will inform City Planning and will be part of the City's 5-year Capital Improvement Plan portfolio. The YMCA Greater Cleveland REACH Program staff is also working with the City Council, the mayor, and Planning Office to introduce an acceptable Complete Streets Ordinance. To continue to tackle the inequitable distribution of power, money, and resources, it is necessary to address inequities in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To successfully tackle the inequitable distribution, it requires more than strengthened government—it requires strengthened governance: legitimacy, space, and support for civil society, an accountable private sector, and for people across society to agree to public interests and to reinvest in the value of collective action.

MEASURING AND UNDERSTANDING THE PROBLEM AND ASSESSING THE IMPACT OF ACTION

B Free CEED: National Center of Excellence in the Elimination of Hepatitis B Disparities

Hepatitis B, a highly preventable disease, is one of the largest health threats for AAPIs. Without treatment or monitoring, 1 in 4 of those infected with hepatitis B virus (HBV) will die from liver cancer or liver failure.[26] Funded in 2007, the B Free CEED: National Center of Excellence in the Elimination of Hepatitis B Disparities, a partnership of the Center for the Study of Asian American Health at New York University School of Medicine and local and national coalition members, is actively involved in advocating local and national policies that will help to decrease hepatitis B disparities among AAPIs, as well as other high-risk groups.

In May 2009, the B Free CEED coalition and 6 partner organizations launched *The National Hepatitis B Community Screening Repository*. This group included organizations from across the country: Asian American Health Coalition of Greater Houston/HOPE Clinic (Texas), Asian Pacific Community in Action (Arizona), Hepatitis B Foundation (Pennsylvania), Ohio Asian American Health Coalition (Ohio), Korean Community Services (New York), and Vietnamese American Cancer Foundation (California), as illustrated in the Figure 1.

This project aims to create a data repository to collect the demographic, serological, and HBV health-related data on individuals participating in community-based screening events across the United States. Many community groups and coalitions have mobilized and conducted local screening events targeting specific Asian American subgroups

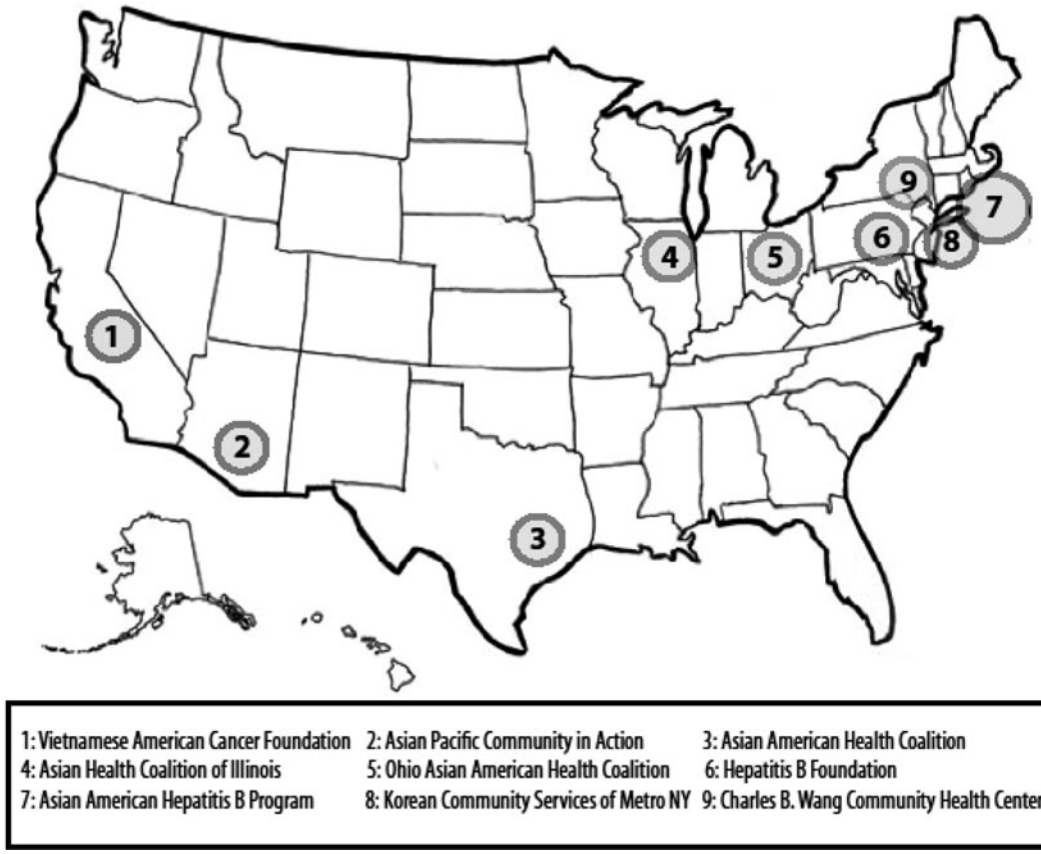

Figure 1. National hepatitis B screening data repository sites. From National Center of Excellence in the Elimination of Hepatitis B Disparities CEED Coalition, 2009.

known to be at high risk for infection. Independent data from these community screenings provide specific epidemiologic evidence of the high prevalence of HBV among Asian and Pacific Islanders. Data from the repository will be used to refine the estimation on the prevalence of chronic HBV and provide much needed information to health care professionals, researchers, and policy makers to guide HBV efforts. Current national estimates of the prevalence of chronic HBV are likely to underrepresent rates among AAPIs. One study has suggested that chronic HBV infection could be as high as 2 million (from the current prevalence estimate of 1.25 million[27]) when one takes into account HBV prevalence in immigrant populations.[28] Also, an underestimation of the true number of infected individuals in the United States has occurred mostly because the highest-risk populations are underrepresented in surveillance studies, and a large percentage of chronically infected individuals remain undiagnosed.

B Free CEED is developing a Markov Model to predict outcomes and economic costs of chronic HBV infection. The model will allow for the prediction of the current societal costs of chronic HBV infection in New York City and nationally and will show the impact of early access to care and treatment on reducing the health disparities from chronic hepatitis B infection.

In addition, the B Free CEED evaluation will be used to identify evidence-based practices and guidelines to improve efficacy of screening, care, and treatment of individuals living

with chronic hepatitis B. The evaluation findings will also be used to inform best practices for identifying high-risk populations, screening practices, and linkages to care programs.

CHICAGO DEPARTMENT OF PUBLIC HEALTH

Similar to other cities across the United States that are combating racial and ethnic health disparities, Chicago is on the front line fighting the unequal distribution of morbidity and mortality for its African American and Hispanic/Latino residents. A Chicago REACH program funded in 2007 by the Centers for Disease Control and Prevention is contributing to this initiative and identifying strategic ways to measure and understand the problem. Findings from their needs assessments are all too familiar to health disparities researchers.[8,9] In Chicago, heart disease, cancer, stroke, diabetes mellitus, and respiratory disease (in sequential order) are among the top-10 leading causes of death and are associated with significant disabilities and decreased quality of life.[29] Both diabetes and heart disease disproportionately affect African Americans and Hispanic residents.[29] Similarly, other related complications such as obesity and hypertension affect these populations disproportionately. In 2003, the Chicago Behavioral Risk Factor Surveillance Survey found higher obesity rates among Hispanic/Latino (31.9%)[30] and African Americans (31.7%) than those among non-Hispanic whites (19.8%).[30] A survey conducted in Chicago found that 44.3% of African American experienced high blood pressure compared with 34.7% of non-Hispanic whites and 24.7% of Hispanic/Latinos.[31]

The Chicago Department of Public Health (CDPH) developed a set of objectives and indicators to understand the impact of health inequities for all of Chicago Lawndale residents. The Lawndale Community Landscape Asset Mapping (CLAM) survey tool, developed by the CDPH's *Lawndale Health Promotion Project* and the University of Illinois at Chicago, was used to assess individual community's environmental resources and to generate baseline data to advocate for policy, environmental, and systems changes. The CLAM explores, through observation and mapping, community-level opportunities for and barriers to healthy behaviors. In each of the CDPH's Center for Community Partnerships communities, local residents were trained and paid to conduct the survey and document the types of food stores; the type, variety, quality, and price of fruits and vegetables sold in each store; as well as other factors such as low-sugar/low-fat aisles, pharmacies within the store, and availability of nutritional information in community places such as schools, businesses, barbershops, and others.

The CLAM concept is based on the notion that health inequities are classified by 4 types of landscapes: (1) *ecological*: air, water, safety; (2) *materialist*: presence of resources such as employment opportunities; (3) *consumption*: resources for purchase; and (4) *therapeutic*: opportunities for promoting a sense of well-being. The CLAM data are collected monthly on the basis of 3 surveys that capture information on the 4 landscapes: (1) *looking around* (census block level) such as parks, schools, beauty shops, and others; (2) *grocery shopping* such as variety of fresh produce, meats, quality of foods, presence of tobacco and alcohol, and others; and (3) *eating out menu* options such as quality, cleanliness, cost, and others. Surveys varied slightly depending on the community area; coalition members in each community revised a standard grocery shopping survey to reflect food shopping needs and preferences in their community. Fresh fruits and vegetables were assessed on the basis of quantity, quality, and price. Quantity was measured by the number and variety of fruits and vegetables overall. The quality ranking was based on a 3-point "appeal" scale ranging from "looks good" to "would not buy."

The CDPH is primarily responsible for data analysis, and the community coalitions use the results to help identify policy, systems, and environmental change strategies to implement in their community action plans. In the *Lawndale Health Promotion Project*,

local community residents conduct the CLAM survey as a form of empowerment and engagement in the issues affecting their area. It is well documented that social and environmental factors significantly impact the health and well-being of individuals and communities. Poverty heightens the burden of disease experienced by the Lawndale residents. According to the 2001 CLAM results, the Greater Lawndale community is an unhealthy place to live in.[32] In addition to concerns about public safety and the many empty lots littered with garbage and abandoned items, which prohibits outdoor activity, there are few places to purchase healthy food, few eating establishments serving healthy foods, and few positive messages displayed on public signs.[32] In North Lawndale, access to affordable and appropriate food is a significant factor attributing to low rates of fruit and vegetable consumption.[32] A recent assessment of the availability and appeal of fresh produce documented only 15 food stores in the entire North Lawndale Chicago metropolitan community. The CLAM data further identified 6 of the 15 food stores as convenience stores and another 6 as corner stores with limited fresh produce options.[32] As a result of these findings and an understanding of the community conditions, the *Lawndale Health Promotion Project* has developed a strategic plan that includes several approaches, one of which is implementing policy and systems changes to increase availability of fruits and vegetables.[32]

CONCLUSION

Medical knowledge is not enough. Western leadership is not enough. Money is not enough. We must depend on each other. Only with respect for what all of us can contribute will we understand the best way to approach global health threats. Only then can we use the abundant resource available in a way that opens up the possibility of global health equity in the twenty-first century.[33(pxiii)]

Achieving health equity is a major challenge facing the United States, and racial and ethnic communities will continue to play a vital role by creating, implementing, and evaluating stronger policy, systems, and environmental change strategies. In addition, the causes of health disparities are multifactorial, and the interventions designed to eliminate them will require multisectorial collaborations that employ these diverse strategies. REACH communities have been committed to this collaborative approach. Their strategies have better informed, engaged, mobilized their communities, and increased our understanding of how the basic determinants of health influence collective and personal well-being in US racial and ethnic populations. REACH communities serve as models for reducing inequities; aspects of these programs have been and will continue to be replicated across the country as evidence of best practices develops.[34-38]

Public health researchers and practitioners are placing greater emphasis on the influence of social and physical environments on our health-related decisions and behaviors. All Americans, regardless of race or ethnicity, are subject to the determinants that contribute to disparities and poor outcomes—just as all Americans will benefit from policies implemented to eliminate disparities.

In essence, when it comes to disparities, we simply do not have the luxury or the time to fund long-term "state-of-the-art" studies. As public and private entities work together and share ideas and resources, we can test different approaches, learn as we go, and share what we learn.

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